Information Summary and Recommendations

Respiratory Care Practitioners Sunrise Review

October 1994

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The Sunrise Review Process

Legislative Intent

It is the Legislature's intent to permit all qualified individuals to enter a health care profession. If there is an overwhelming need for the state to protect the public, then entry may be restricted. Where such a need to restrict entry and protect the public is identified, the regulation adopted should be set at the least restrictive level.

The Sunrise Act, RCW 18.120.010, states that a health care profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public and the potential for harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public can reasonably benefit from an assurance of initial and continuing professional ability; and
- The public cannot be protected by other more cost effective means.

There are three types of credentialing:

- *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practiced and, if required, a description of the service provided. A registrant could be subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
- *Certification.* A voluntary process by which the state grants recognition to an individual who has met certain qualifications. Non-certified persons may perform the same tasks, but may not use "certified" in the title. A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
- *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to persons who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensee is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

Overview of Proceedings

The Department of Health notified the applicant group, all professional associations and board, committee, and commission chairs and staff of the Sunrise Review. Meetings and discussions were held and documents circulated to all interested parties.

Regulatory agencies in all other states were requested to provide sunrise reviews, regulatory standards, or other information which would be useful in evaluating the proposal. A literature review was conducted. Staff have reviewed all submitted information and asked for feedback from interested parties.

A public hearing was conducted in Olympia on September 30, 1994. The hearing panel included department and State Board of Health staff. Persons were allowed to give time limited presentations. A general discussion and response period followed the hearing as well as an additional ten-day written comment period.

Following the public hearing and additional written comments, a recommendation was made based on all information received and in consultation with the public hearing panel. The applicant group and other interested parties were briefed on the draft recommendations. The proposed final draft was reviewed and approved by the Health Systems Quality Assurance Assistant Secretary and Department Secretary. The final report was transmitted to the Legislature via the Office of Financial Management.

Executive Summary

The Washington Society of Respiratory Care Practitioners introduced House Bill 2015 to the Legislature to increase the level of regulation of respiratory care practitioners from certification to licensure and to change the scope of practice. The bill clarifies some procedures within their scope of practice and changes the scope to include:

- general anesthesia with the administration of other prescribed medical gases;
- administration of prescribed pharmacological agents removing the clause "related to respiratory care" and adding "to the extent of training";
- insertion of artificial airways as prescribed removing the restrictive clause "regarding the cutting of tissues";
- diagnostic monitoring and therapeutic interventions for desaturation, ventilatory patterns, and related sleep abnormalities; and
- additional acts requiring education and training which are recognized by medical and respiratory professions as proper.

Input was provided by the Washington Society of Respiratory Care Practitioners, the Washington State Nurses Association, the Washington State Medical Association, the Washington State Residential Care conference, Ingrum Residential Care Centers, Inc. and one private citizen.

The department found that most respiratory care practitioners are credentialed and that licensure will not assure competency and will not increase the reporting of poor practice. There is a potential for physical harm in the acute care setting, but back-up help and physician presence is available. At this time the potential for harm in the home setting appears to be remote.

In addition, the department found that the expanded scope of practice included in House Bill 2015 does increase the potential for harm. Practitioners would be able to cut tissue, administer *any* anesthetic gas or other medication, and perform other medical procedures which are not included in their approved education. Family members are not exempted from care, and the bill does not contain a title for the practitioner.

The department found that a potential shortage of respiratory care practitioners is possible if licensure is adopted. Hearing testimony also related to procedures being provided by both practitioners and students that are beyond their scope of practice.

The department believes that respiratory care practitioners have the education and ability to administer nitrous oxide during procedures performed by physicians.

The following recommendations are proposed by the Department of Health:

1. The current level of regulation of respiratory care practitioners should remain at certification.

If House Bill 2015 is considered for passage, there is potential for harm from the extended scope of practice. The Department of Health recommends the following changes:

2. In Section 4(1) line 10, *insert* the words "to include nitrous oxide" after medical gases.
3. In Section 4(1) line 11 *do not delete* the words "exclusive of general anesthesia".
4. Change the word "prescribed" to "ordered" wherever the word occurs.
5. In Section 4(4) line 15, *do not delete* the words "related to respiratory care".
6. In Section 4(9) line 24, *do not delete* the words "without cutting tissues".
7. In Section 4(12) line 36, *insert* before the semicolon "to aid the physician".
8. In Section 4(13) line 38, *insert* the words "respiratory care" after "additional acts".
9. In Section 4(13)(d) page 4, line 21, after this subsection *add* subsection (e) The practice of respiratory care by a family member.
10. Remove the grandfather section from the original statute (RCW 18.89.130 Certification - Waiver of Examination).
11. The recognized title for practitioners should be added to New Section 2.

Most of these changes restore the act to its original scope of practice. However, there are some additions that will aid respiratory care practitioners in their practice.

Current Regulation

Washington State currently has a voluntary certification program for respiratory care practitioners, Chapter 18.89 RCW, established by the legislature in response to a 1985 sunrise recommendation by the State Health Coordinating Council.

There are approximately 1,498 state certified respiratory care practitioners living in the state. The Washington Society of Respiratory Care Practitioners lists its membership at 425 members. The society believes there are another 700 practitioners not state certified who are active in the clinical area. The total, 1,125 practitioners, is less than the total of state certified practitioners. Even counting part-time FTEs, it appears that there are very few, if any, practicing respiratory care therapists who are not state certified. During calendar year 1993, 135 applications for certification were received at the Department of Health. Each year about 82 individuals graduate from Washington respiratory care training programs.

Proposal for Sunrise Review

Representative Dennis Dellwo, House Health Care Committee Chair, has requested that Department of Health conduct a Sunrise Review on House Bill 2015 forwarded by the Washington Society of Respiratory Care Practitioners. This bill will increase the level of regulation of respiratory care practitioners from certification to licensure and will clarify and/or change the scope of practice. The bill removes the definition of rural hospitals and adds non-restrictive clauses for students and other credentialed professionals providing respiratory care under their scope of practice.

The bill clarifies the following within the scope of practice:

- the insertion of devices for venous, arterial or capillary blood;
- the collection of cardiorespiratory specimens; and
- the use of mechanical support, to include hyperbaric support.

The bill changes the scope of practice to:

- include general anesthesia with the administration of other prescribed medical gases;
- allow the administration of prescribed pharmacological agents removing the clause "related to respiratory care" and adding "to the extent of training";
- provide cardiopulmonary resuscitation at the level of advanced cardiac life support or pediatric advanced life support;
- allow insertion of artificial airways as prescribed removing the restrictive clause "regarding the cutting of tissues";
- add the diagnostic monitoring and therapeutic interventions for desaturation, ventilatory patterns, and related sleep abnormalities; and
- include additional acts requiring education and training which are recognized by medical and respiratory professions as proper.

Summary of Information

Department staff reviewed the information received during the review process. Additional information was solicited from interested parties and other information was provided to the department voluntarily. This "Summary of Information" section provides the department's paraphrasing of all documentation received. It does not reflect the department's findings, which are found in a later section of this report.

The summary is divided into three parts which corresponds to the three main criteria (harm to the public, benefit to the public, and other means of regulation) given by the legislature to determine if a profession should be regulated by the state and if so, to what extent.

A. Harm to the Public

(Headings in italics indicate the source of the information.)

Washington Society of Respiratory Care Practitioners

Safe care requires competence and skill. Because some services that were traditionally provided in a hospital setting are now being offered in a home setting, and since health reform will probably move more respiratory services into the home setting where practitioners will not have support professionals readily available, the level of regulation needs to be licensure--a level that is mandatory credentialing for all practitioners.

Home care in the future will require independent decision making involving a patient population of all ages with a variety of procedures; but home care is only one of the sites where expansion will occur. Also, it is expected that the intensity of care will increase. If there is no mandatory licensure, the potential for harm while practicing without attendant supervision will increase rapidly.

The present level of credentialing, certification, is voluntary, therefore many practitioners have not become certified. The society believes that, because of the voluntary status, most people do not realize that incidents causing harm can be reported to the department's Respiratory Advisory Committee for investigation and possible sanction under the Uniform Disciplinary Act (UDA).

The society's report contains many articles referring to:

- rural hospitals where support is not appropriate;
- the practice and skills of this profession as life-supporting with invasive techniques;
- protocols under which practitioners work; and
- the need for practitioners to understand theories which support protocols.

The report cited fifty-seven incidents of harm to patients. Two were committed by uncertified therapists, two by nurses, and fifty were committed by certified respiratory care practitioners (three were before 1986).

Public Letters

The department received comments from 80 people--60 Respiratory Care Practitioners, 16 physicians, nurses, one pharmacist and a hospital department manager. The comments were favorable for licensure of respiratory care practitioners citing the reasons stated in the society's report (see above). Also, an educator promised to increase program requirements to incorporate the new procedures that are included in the scope of practice; the physicians all work with respiratory care practitioners in hospital and office settings and wrote about their dependence on these therapists when working with pulmonary patients; and the nurses wrote about their increased workload in the new hospital systems of patient focused care and the importance of knowing the knowledge base of persons with whom they work. Licensure for respiratory care practitioners would indicate to nurses that the practitioner possesses a given level of education and skill proficiency.

Medical Quality Assurance Commission

There is very little in the educational requirements which would confirm an adequate background in pharmacology for cardiology (cardiopulmonary) medications and for anesthesia. Nitrous oxide is a relatively safe gas but can contribute to arrhythmia. Tracheotomy (a surgical procedure) and intubation are not appropriate procedures for respiratory care practitioners with one or two years of education.

Practitioners are accountable to the patient and to the physician or other health care professionals directing patient care, as well as to themselves; they do not practice independently.

In addition, the obtaining of "specimens" could include biopsies, a procedure which is not appropriate. The other changes in scope of practice are a broad mandate. The Advisory Committee could easily vote many expansions of their scope of practice into rule.

Washington Association of Nurse Anesthetists

Nitrous oxide is a general anesthetic and the intended outcome, conscious sedation, could easily lead to general anesthesia. Respiratory care practitioners do not have education to understand the complications of this class of medical gas and they would have the ability to administer these gases in the home setting if a painful procedure were to be attempted. Versed, another drug they wish to use, is a controlled drug with adverse side effects and requires extensive knowledge in pharmacology to administer safely.

Who will decide what the term "to the extent of training" means? Physiological support could include blood transfusions, intravenous fluids and vasoactive drugs, all beyond their scope and level of education.

Department of Health Literature Search

Respiratory therapy is a health care specialty where practitioners provide care *under medical supervision* in the assessment, diagnostic evaluation, treatment, management, and care of patients with deficiencies and abnormalities of the cardiopulmonary system. Respiratory care practitioners must practice under the supervision of a physician, but the normal circumstance is to practice under protocols, not direct supervision. By increasing the scope of practice, existing protocols could change allowing practitioners to provide more services.

Potential for Harm

Many authors believe respiratory care does present a number of potential threats to the public health--threats magnified by the evolution of the field from a hospital-based service (with attendant supervision) to a home-based service. As early as 1986 Nebraska reported that the need for additional regulation of the profession was intensified by practice outside the hospital setting because recipients of this care are not in a position to 'shop around' (Nebraska, 1986). The State Health Coordinating Council reported the potential for harm is immediate, not remote, and can be life threatening. The Council was especially concerned about provisions of these services in the home setting where peer review and back-up is not readily available (Washington, 1985).

The state of Colorado reported a clear potential for harm resulting from the unregulated practice of respiratory care which, in many instances, is highly invasive and, sometimes, is delivered in the home. "Nevertheless, the respiratory care profession is comprised of highly skilled and dedicated individuals who typically adhere to or *exceed* those educational, credentialing, and professional standards of care with which they would have to comply under state licensure laws" (Colorado, 1993).

In the Washington Society of Respiratory Care Practitioner's report there was no evidence of harm done outside the institutional setting. This could be due to the importance placed on physician-to-physician contact between the specialist and the community-based physician before hospital discharge, because the success of home care depends on the prescribing physician who supervises the respiratory care practitioner (Goldberg, 1989).

Hawaii reported the potential for harm is *remote* because respiratory therapists work under direct medical supervision and are employed by knowledgeable health care agencies such as hospitals, nursing homes, durable medical equipment companies, home health agencies, etc. (Hawaii, 1986). While some argue that the risk for harm in the home setting is increased (Colorado, 1993), research shows that: (1) in Washington and other states home health agencies must comply with numerous federal and state regulations in order to participate in the Medicare program; (2) there is usually a governing board for the agency with written policies for agency operations; and, (3) nationwide all respiratory services are provided under the supervision of physicians (Mitchell, 1989).

Contact with home health agencies within the state found that home respiratory care requiring providers, certified or not, is rare. In most instances family members care for the

patient or the patient is taught self-care. If services of a practitioner are needed, the agency contracts with hospitals or durable medical equipment companies to use their staff. Agencies that provide home care services must be licensed as a home health agency and the agency can have that license revoked if incompetent providers of care are used.

Dunne (1977) states that as the traditional health system changes, respiratory therapy, one of the more dynamic allied health specialties, will most certainly see its share of role restructuring with an expanded role; but, more recently Stoller (1993) found evidence for overuse of respiratory care. There have been tremendous changes in Washington's health system; but, in the home setting respiratory therapy *requiring a practitioner* is still a rare event.

Unsafe Practitioners

Mandatory credentialing would bring all practitioners under the Uniform Disciplinary Act whereby complaints are registered, investigated, and, if there is cause, disciplinary action is taken. Information on disciplinary actions is public knowledge and can serve to protect the public from unsafe practitioners. A review of Department of Health records shows that in the last two years only seven complaints have been received. Two were closed because there was no cause for action, and the other five are under investigation at this time. There have been no disciplinary actions to date for respiratory care practitioners. Other states report that most complaints relate to tortious conduct rather than to the quality of care administered by the practitioner (Colorado, 1993). Civil laws are appropriate for these cases.

This profession is privately regulated by recognized effective private organizations, including a national voluntary certification authority, national and state-affiliated professional organizations, and a national health care accreditation program. These organizations promulgate standards of practice for the profession, accredit the health care institutions in which they practice, and certify their competence as entry level practitioners. In addition, the national credentialing organization is authorized through its Judicial and Ethics Committee to prosecute disciplinary actions against its members upon their conviction of criminal or negligent conduct relating to the practice of respiratory care (Colorado, 1993).

Harm from Non-licensed Practitioners

Non-certified respiratory care practitioners are often from other health care professions. In Arizona, for example, only 1% of practicing therapists have on the-job-training. These individuals tend to move in from professions such as LPN or paramedic, professions with knowledge of assessment and care (Arizona, 1990).

State licensure, the most strict form of regulation, is one of the criteria causing shortages of health care personnel. While at the present time cross-trained workers can help, after licensure qualified persons must be hired. Research suggests that even though this profession often uses invasive procedures, a shortage can do more harm to the public than the *remote* chance of harm from non licensed practitioners (Mitchell, 1989).

Conclusion

Changes to this profession are most certainly evolving as health reform proceeds. However, evidence shows that in Washington State home care requiring the skills and knowledge of a respiratory care practitioner is rare; when required, certified therapists are used; and, to date, there has been no evidence of harm in the home care setting. To protect their license, home health agencies will hire qualified practitioners whose standards of care are higher than those a mandatory licensure law would contain.

B. Benefit to the Public

(Headings in italics indicate the source of the information.)

Washington Society of Respiratory Care Practitioners

The public would benefit because licensure is mandatory and the required education plus the credentialing examination would ensure competency. Licensure also ensures that the knowledge underlying the protocols has been gained, and because practitioners would understand the protocols, they would practice within these boundaries.

With licensure the public could identify qualified respiratory care practitioners who understand the technology of the various machines and skills needed. Currently, the skill mix of providers is changing, but licensed providers would meet certain education requirements and would have the capability of performing assessments and making decisions without constant supervision.

Another benefit to the public is the increased competency of the provider. Under licensure the public could be confident of competency because:

- all practitioners would be under one law as opposed to voluntary certification;
- there would be standards of practice;
- reciprocity would be in place for practitioners moving into the state;
- practitioners would take the national association's examination;
- biennial expiration date for renewal;
- compliance with the Uniform Disciplinary Act (UDA);
- UDA gives the ability to regulate quality of care;
- no restrictions on other licensed personnel;
- quality would be assured through the Code of Ethics of the national association.

There would be no cost increase because the mechanism for licensing is already in place. License fees will pay the administrative costs; in fact, the fees could be less with more credentialed people sharing the cost. Mandatory licensure also provides a system to track unsafe practitioners.

Washington State Residential Care Conference and Ingrum Residential Care Centers, Inc.

Licensure is supported because there would be greater flexibility for care to residents in Adult Family Homes. Licensed practitioners would be able to bill directly to Medicare or Medicaid for services allowing the homes to contract directly with the practitioner for ventilator services.

Department of Health Literature Search

Who Will Benefit

Proponents of licensure argue that: the public is protected from incompetent or unethical practitioners; it is a key to a better-trained work force; and the practitioner receives more respect from both patients and other professionals (Low, 1992; Barman, 1990).

Opponents state that the issue is *who* benefits most, the public or the licensed professional. The stringent requirements depriving workers of jobs and dissuading students from entering the field, and the increase in cost of care are only two problems with licensure that provide no benefit to the public. Restrictive entry levels also make it difficult for international practitioners to become licensed (Low, 1992; Barman, 1990; Begun, 1990, Lawson, 1989; Shapiro, 1976; Kernaghan, 1976). Shapiro believes the quality of care does not depend on minimal licensure standards but rather is determined by each individual, staff and institution. Additionally, he states that "no minimum level of licensure will *legitimize* or increase the acceptance of [practitioners] in the health care community" (Shapiro, 1976).

Education and Examination

Concentrating on the education and examination criteria as the measure of competence should promote high quality service (Shannon & Dietz, 1989). Washington's current law regulates education through programs accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Joint Review Committee for Respiratory Therapy Education.

As early as 1976 individuals who had earned the national association's credentialed titles, CRTT and ARRT, were recognized as possessing expertise in the field of respiratory therapy, a clinically-oriented discipline. The state recognizes the entry level certification examination used by the National Board of Respiratory Care, Inc. (NBRC). Candidates who pass the examination receive national certification, a credential recognized in all states by hospitals, nursing homes and other agencies. The NBRCs International Credentialing Committee is also a liaison for foreign countries providing information on the development of examinations and reciprocity policies for using the NBRC examinations.

Practitioner Entry Level

Respiratory therapy is a field where several entry levels now exist and where experience counts as much as education for jobs and promotions. The literature shows opposing views about education--whether it should be two years or four years for entry level practitioners. In Washington there are six two-year training programs. Two of these programs also include a one-year program. At this time House Bill 2015 does not exclude one year graduates from licensure. The society's report states the skill mix of providers is changing and licensure is a method of credentialing that guarantees a stated level of competence at entry into the profession.

Assuming that the one year programs are not to be phased out, the level of competence for licensure would be at the one year level. The public would not benefit or be able to identify those practitioners with two year or four year degrees.

If, however, the one year programs are to be phased out, restricting the entry level at a time when there will be a health system in which all citizens of the state are guaranteed care will create a shortage that is more serious than the shortage of practitioners in rural areas today.

Conclusion

These opposing themes for and against licensure are found over and over again in the literature; but, authors agree that the costs of licensure generally increase the costs of care (Barman, 1990). Education costs money and increased education is reflected in the cost of care. If the cost of care increases, the benefit to the public is reduced.

In light of the profession's voluntary compliance with private occupational standards, the public will not benefit from state licensure. In fact, in states where licensure has occurred, the evidence suggests it is "ineffective due to the low complaint rate and disciplinary proceedings" (Colorado, 1993).

C. Other Means of Regulation

(Headings in italics indicates the source of the information.)

Washington Society of Respiratory Care Practitioners

The following are alternatives to licensure and are not satisfactory for respiratory care practitioners for the reasons given:

- The employers of practitioners could be regulated, but it would be cumbersome and redundant to regulate the employment agencies who would regulate the practitioners.
- The service could be regulated instead of the individual, but there are many different levels of education and a system would be needed to establish entry levels of confidence due to the invasiveness and skill requirements of the occupation.

- Registration does not require education or competence and is not appropriate for occupations with invasive procedures.
- Certification is voluntary, therefore anyone can practice as long as they do not claim to be a respiratory care practitioner.

Licensure of respiratory care practitioners would provide the following advantages for the state of Washington:

- gives professional control to a practice that is invasive and requires skills and competence;
- places the burden of competency on the individual providing care;
- provides safety in future care settings that are less structured;
- protects the public for specialized and invasive skills given to all age groups (neonates to elderly) in alternative sites and flexible independent modes; and
- states a scope of practice in the licensure act for a variety of procedures and intensity of care given to a broad patient population.

Department of Health Literature Search

"The world is more complex than allowing for only two alternatives, regulation or no regulation. People will support degrees of government regulation. The question to research is, how many rules are beneficial?" (Begun, 1990). Nichols believes the ongoing demand for licensure is the result of rapid technological advances, increased competition among health personnel, and transformation of the health care financing and delivery systems. Significant policy questions to ask are, "What is the relationship between granting licensure to new groups versus expanding the scopes of practice for existing groups to each of the following: cost control, innovative use of personnel, promoting life styles conducive to good health, reducing the occurrence of preventable conditions, and providing care that is adequate and accessible (Nichols, 1989)?"

Low states that licensure began for the self-employed and was instigated to protect the consumer from inept or unqualified health professionals. His recent study on licensure contained the following conclusions (Low, 1992):

- the rationale most used for licensure is protection of the public;
- the professional has a conception of benefits and harm that differs from that of the public;
- even a title act (certification) provides protection in that practitioners cannot publicly refer to themselves as a practitioner without the minimum qualifications;
- there is no difference in practice in states with licensure from states without; and
- licensure protects professionals from too much competition.

Low's study found that costs increased by 16% with licensure, an increase due mostly to the need for increased education (Low, 1992).

Licensure Issues

The values of regulation belong to the public, not the experts, and regulation of a health profession does not exist in a vacuum. If this is true, then the issues or trends relevant to licensing, according to Nichols (1989), are: mandated benefits and third party reimbursement; fraudulent degrees; immunity clauses; composition of licensing boards; expanding scopes of practice; impaired professionals; and continuing competency. Not addressed by Nichols were education and costs, supervision and protocols, cross-credentialing and cross-skilled professionals, and the restrictiveness of licensure with resulting manpower shortages.

Mandated Benefits and Third Party Reimbursement: Respiratory care practitioners will not receive new benefits or reimbursement with a licensure law. If they are credentialed (registered, certified or licensed), they will receive both when health care reform is in place.

One of Washington State's largest payors is currently revising schedules to include state certified respiratory therapists in its payment schedule. The payor has been working with representatives of this profession. Medicare Part A and B will not reimburse until HCFA places this care on its schedule. Medicaid will not automatically reimburse respiratory care practitioners even if the practitioner is licensed. The entire practice must first be analyzed within the context of care given.

Ventilator care cannot be given in boarding homes unless the patient resides in a separate room that can be locked, has bathroom facilities, including a refrigerator and has emergency power.

Fraudulent Degrees: Because of the employer/employee relationship found in this profession, the problem of fraudulent degrees has not been reported. Each agency or institution is responsible for the credentials and practice of the people hired.

Immunity Clauses: These clauses are found in credentialing laws, but when broad statements are made to exempt anyone who practices the same procedures, the need for licensure becomes more remote. There are many health professionals who provide respiratory care procedures as part of their scope of practice and they are exempted in House Bill 2015. In the home setting, family members provide the majority of care. Registered nurses are allowed to call themselves respiratory care practitioners.

Composition of Licensing Boards: Washington's licensing boards (or committees, commissions, etc.) include a very small minority of public members making the board not only representative of the profession but with nearly identical interests as the profession including protection of the scope of practice (Shannon & Dietz, 1989). This does not represent the public's interest.

Expanding Scopes of Practice: A scope of practice can only be protected by licensure which then restricts entry into the profession. This bill includes an expanded scope.

Impaired Professionals: In Washington State the Uniform Disciplinary Act provides the public with legal means to discipline and sanction the credentials of health care professionals. Mandatory registration, the least restrictive form of credentialing, will accomplish this process as does certification and licensure.

Continuing Competence: There is no convincing evidence of a tie between licensure and competence (Kernaghan, 1976). In fact, licensure does not provide initial or subsequent competency of professionals. Research shows that a "perfectly competitive market", a market where all can participate, is the optimal way to structure consumer-provider exchanges (Begun, 1990). Additionally, the Health Services Act of 1993 provides for continuing competence of the health care workforce, a task to be accomplished by the Certified Health Plans, and the standards of practice of the professional organization are assumed to be followed by practitioners who are credentialed in this state.

Education and Costs: Licensure serves as a protection of the scope of practice and this, in turn, usually creates a specific education route. But, education costs money, and licensure with its natural tendency to escalate education will increase costs (Shannon & Dietz, 1989; Moser, 1979, Lawson, 1989). The expanded scope of practice will most certainly increase education requirements.

For many years there has been a dissension among therapists and educators about on-the-job training versus formal education (Powers, 1976). With licensure, the normal change is to require education from accredited schools only and remove WACs referring to on-the-job training. The current WAC already requires 38 college quarter credits threatening on-the-job training for persons skilled in other areas of health care who wish to become respiratory care practitioners.

Supervision and Protocols: Respiratory care practitioners generally follow protocols while working under the supervision of a physician. The society states a practitioner doing home care may never see the physician. However, the patient primarily looks to the physician for care, not the respiratory care practitioner, placing importance on the relationship between practitioners and agencies where they work. According to the agency's license, it is the agency, not the practitioner, that guarantees the competency of the provider. In the future it will be the Certified Health Plan's responsibility.

Cross-Credentialing and Cross-Skilled Professionals: Respiratory care practitioners see a need for persons in their professions to be cross-skilled and they believe this would be a benefit to the public (Beachey, 1988); however, licensure would nullify this benefit by restricting cross-training of others *into* the respiratory care profession creating a potential for shortage of providers.

Restrictiveness of Licensure: At the time Florida passed their licensure bill the belief that professions must be 'protected' through licensure was rampant; but, many practitioners thought the bill was premature and that licensure was not needed. Florida

practitioners now believe licensure is too restrictive and do not want to be in the same position as doctors and nurses (Swanbrow, 1978).

Because there are approximately 80 graduates each year from respiratory care practitioner educational programs (both one and two year programs), there would be no benefit to the public by restricting entry with a licensure law, the most restrictive form of credentialing. The potential shortage would not benefit the public if care is not received when needed (Reade, 1982). In Florida the restrictive nature of licensing reduced the number of people who can legally practice and temporarily reduced the available pool of respiratory therapists. As a result, the licensed practitioner was a more marketable commodity and pay increased as much as 40% in some institutions (Lawson, 1989).

Conclusion

Licensure is improper if it is earned or deserved, if it is given as recognition of abilities and skills, or if it is for protection from unfair encroachment by other health professions. National standards and credentialing are preferable to state credentialing; and, standards of practice can be higher with voluntary certification than the minimal entry level standards required for state licensure (Position Paper, 1976). The national body should rigorously encourage the government to tie reimbursement to services rendered by its certified practitioners. (Block, 1981).

Public Hearing

Sixteen people attended the hearing and twelve testified in favor of HB 2015. Eleven were members of the Washington Society of Respiratory Care Practitioners representing the society's report, respiratory care in the home setting and education. One person represented the public as a former user of respiratory care in the home.

Testimony from practitioners supported the bill and also included the fact that practitioners and students are practicing beyond the scope of practice found in the present act.

Findings

1. **Most respiratory care practitioners are credentialed.** There are 1,498 state certified practitioners with active certificates, Washington addresses and under 64 years of age. The society reports approximately 1,125 persons are practicing. When questioned, society representatives stated the number (1,125) is full time equivalents (FTEs); therefore, it is estimated that the extra 273 certified practitioners make up the difference for part-time FTE counts.

2. **There is a potential for physical harm in the acute care setting, but it is remote in other settings.** The most invasive procedures are done in hospital settings where back-up help is available. Procedures done on persons who are chronically ill become more routine and the potential for harm becomes remote. Chronically ill persons are placed in nursing homes, boarding homes, adult family homes or they remain in their private home. The Department of Health determined that home care is still a rare event, but when it does happen, facilities utilize certified

therapists who place the equipment needed for therapy, educate the family on giving care and make routine calls to ensure proper therapy.

3. **The assumption that licensure assures education and competency is false.** To be state certified, the practitioner must have passed national examinations and be registered or certified with the national society. It can be assumed the practitioner has knowledge of, and understands, the standards of practice of the profession. If these practitioners were to be licensed, they would receive the same education, take the same examinations and be licensed in the same way they are now certified.

   In the health care field, agencies must be licensed by the state and accredited by different organizations in order to receive Medicare and Medicaid payments. One function of the employer's license is to assure competency of its employees. Continuing competency will be assured through the Quality Improvement Programs that will be part of the Certified Health Plan's contract.

4. **The assumption that licensure would increase the reporting of poor practice is false.** The WACs already require mandatory reporting of practice below standards and, since most practitioners are already certified, reporting should occur. The society must educate the public, employers and all practitioners about the system of reporting and the Uniform Disciplinary Act.

5. **Under the proposal there is a potential for harm due to the expanded scope of practice without increased education requirements.** Practitioners would be able to administer any anesthetic gases, cut tissues to insert tracheotomy tubes, administer any medications to the extent of their training, and perform any additional acts deemed appropriate by physicians and practitioners. At the hearing the society presented evidence only for nitrous oxide and two medications that registered nurses must administer. According to testimony, many practitioners appear to be practicing beyond their scope of practice.

   When addressing the expanded scope of practice, there is no provision for additional education or for distinction between practitioners with one year of education from those with two years or four years. The standard norm for education is the two year associate degree, however there is a substantial number of practitioners with a one year degree.

6. **Family members are not exempted from care.** The bill does not state that respiratory care is given in a setting of "fee for service", and RCW 18.71.030(2) exempts only the domestic administration of family remedies; therefore, it is not clear if family members would be able to give respiratory care in the home setting.

7. **The "grandfather clause" is not clear.** The bill makes no provision for grandfathering into licensure, but the original grandfather clause was not removed from the statute. The society does not wish to grandfather those who are not already certified into licensure.

8. **There is no title for the practitioner of respiratory care.** HB 2015 removes the title section found in the original statute and protects only the scope of practice. Protection of the public should be the final goal and the public must be able to recognize a licensed practitioner.

9. **RCW 18.89.040(12) is not clear.** This subsection should be clarified to state that the procedures are to *aid* in the diagnosis of a patient, and not for diagnosis or prescribing by a respiratory care practitioner, or to enable a practitioner to start an independent practice.

10. **Students are performing procedures for which they are not trained.** Licensure and an increase in the scope of practice will not change the acts students of educational programs perform. This is a problem with instructors at the various schools.

11. **Credentials of employment agency practitioners sent to work as respiratory care practitioners are not being verified.** Harm can be done by practitioners who perform procedures for which they are not qualified, but this is a problem for the management of the hospital. Licensure cannot change this practice. Management must be educated to verify all qualifications of persons working on their premises.

12. **A shortage of practitioners is possible.** Literature shows that one reason a shortage of practitioners follows licensure laws is because licensure is very restrictive for entry into practice. With the advent of health care reform whereby all citizens will have care provided, a shortage could result that would be harmful to the public. There is no evidence that licensure will increase the number of practitioners in rural areas; in fact, a decrease can be predicted.

13. **Practitioners have the ability and knowledge to administer nitrous oxide.** This gas produces conscious sedation that is used during some medical procedures. The respiratory care practitioner works under the direction of a physician and would be doing so when administering this gas. The practitioner should not administer nitrous oxide if a physician is not present.

Recommendations

- The current level of regulation of respiratory care practitioners should remain at certification.

  Rationale:

  a) Data shows that most practicing respiratory care practitioners are now certified.

  b) Practitioners will have the same level of education and entry level examination regardless of certification or licensure.

  c) Licensure is restrictive; with restrictive entry into the field, a resulting shortage would not benefit the public.

  d) The potential for harm in settings other than acute care is remote because most invasive procedures are performed in the hospital.

If, however, House Bill 2015 is considered for passage, there is a potential for harm from the extended scope of practice. The following nine changes to the scope of practice are recommended:

- Do not delete the words "exclusive of general anesthesia" from the original statute, but add an allowance for the administration of nitrous oxide (RCW 18.89.040(1).

  Rationale: nitrous oxide is a common anesthetic gas that can be safely administered in acute care settings in order to accomplish respiratory care procedures.

- Do not delete the words "related to respiratory care" from the original statute (RCW 18.89.040(4).

  Rationale: The physician responsible for supervision and protocols of the respiratory care practitioner can decide if a drug is related to respiratory care. The scope should not include all drugs.

- Do not delete the words "without cutting tissues, of artificial airways," from the original statute (RCW 18.89.040(9).

  Rationale: The education of respiratory care practitioners does not support a procedure such as a tracheotomy, the cutting of tissue to insert an airway.

- Subsection RCW 18.89.040(12) should be amended to clarify that the procedures are to aid the physician in diagnosis and not for independent practice.

  Rationale: A respiratory care practitioner must practice under the supervision of a physician.

- Insert the words "respiratory care" after "additional" on line 38 of Section 4, RCW 18.89.040(13), so that the line reads, "The performance of such additional respiratory care acts requiring . . . "

  Rationale: The subsection needs to be clear that it is only respiratory care acts.

- If the new scope of practice is approved by the Legislature, the curriculum should be expanded for one year programs, or the statute should delete one year programs from licensure. The curriculum for two year programs should be expanded to allow the additional practice procedures found in House Bill 2015.
  Rationale: The new scope is too broad for one year of education.

- In Section 4(13) insert "(e) The practice of respiratory care by a family member."
  Rationale: It is not clear that family members are exempted, but they are responsible for most home care.

- Remove the grandfather clause from the original statute (RCW 18.89.130) so that the intent of the society is clear; the society believes that only certified persons as of the date of licensure should be licensed.
  Rationale: The new scope of practice requires more education than those practicing with on-the-job training and those with one year of education.

- In New Section 2, add titles of practitioners regulated by HB 2015.
  Rationale: The public should be able to identify licensed personnel. Practitioners are now identified by their national association titles, CRTT and ARRT.

Respiratory Care Practitioners
Regulation in Other States

State	Status of Regulation	Comments
AZ, CA, FL, ID, IA, KS, LA, MA, MD, ME, MS, MT, ND, NE, NH, NJ, NM, NY, OH, OR, PR, RI, SD, TX, UT	Licensed	ME scheduled for 1998 Sunset. NY '92 law not implemented yet. Under medical board: FL, ID, MD, OR, SD. Two levels of practitioners: NM, TN.
CT, GA, KY, IN, NM, PA, SC, TN, VA, WA, WI	Certified	Under medical board: GA, PA, SC, VA, WI. Two levels of practitioners: NM, TN.
MN, MO	Registered	
AK, Al, AR, CO, DC, DE, HI, IL, MI, NV, NC, OK, VT, WV, WY, Guam, Mariposa, Saipan	None	CO '93 Sunrise did not pass. DE, DC proposing legislation.

Forty-eight states and territories responded to a request for information on credentialing of respiratory care practitioners. In 1993 the Colorado Sunrise Report, the latest report received by this department, recommended against credentialing. Two respondents are working on legislation to be proposed.

Licensed	25 states or territories
Certified	11 states
Registered	02 states
No regulation	18 states or territories

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H-1509.1

HOUSE BILL 2015

State of Washington 53rd Legislature 1993 Regular Session

By Representatives Dellwo and Thibaudeau

Read first time 02/22/93. Referred to Committee on Health Care.

AN ACT Relating to respiratory care; amending RCW 18.89.010, 18.89.020, 18.89.040, 18.89.050, 18.89.060, 18.89.070, 18.89.080, 18.89.090, 18.89.110, 18.89.120, 18.89.130, 18.89.140, 18.120.020, and 18.130.040; adding a new section to chapter 18.89 RCW; repealing RCW 18.89.900; providing an effective date; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 18.89.010 and 1987 c 415 s 1 are each amended to read as follows:

The legislature finds that ((~~it is necessary to regulate the practice of respiratory care at the level of certification~~)) in order to ((~~protect the public health and safety~~)) safeguard life, health, and to promote public welfare, a person practicing or offering to practice respiratory care as a respiratory care practitioner in this state shall be required to submit evidence that he or she is qualified to practice, and shall be licensed as provided. The settings for these services may include, health facilities licensed in this state, clinics, home care, home health agencies, physicians' offices, and public or community health services. The respiratory care practitioner is directly accountable and responsible to the individual consumer for the quality

of respiratory care rendered. Nothing in this chapter shall be construed to require that individual or group policies or contracts of an insurance carrier, health care service contractor, or health maintenance organization provide benefits or coverage for services and supplies provided by a person certified under this chapter.

NEW SECTION. **Sec. 2.** A new section is added to chapter 18.89 RCW to read as follows:

After the effective date of this act, it shall be unlawful for a person to practice or to offer to practice as a respiratory care practitioner in this state or to use a title, sign, or device to indicate that such a person is practicing as a respiratory care practitioner unless the person has been duly licensed and registered under the provisions of this chapter.

Sec. 3. RCW 18.89.020 and 1991 c 3 s 227 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Advisory committee" means the Washington state advisory respiratory care committee.

(2) "Department" means the department of health.

(3) "Secretary" means the secretary of health or the secretary's designee.

(4) "Respiratory care practitioner" means an individual ((~~certified~~)) licensed under this chapter.

(5) "Physician" means an individual licensed under chapter 18.57 or 18.71 RCW.

((~~(6) "Rural hospital" means a hospital located anywhere in the state except the following areas:~~

~~(a) The entire counties of Snohomish (including Camano Island), King, Kitsap, Pierce, Thurston, Clark, and Spokane;~~

~~(b) Areas within a twenty mile radius of an urban area with a population exceeding thirty thousand persons; and~~

~~(c) Those cities or city clusters located in rural counties but which for all practical purposes are urban. These areas are Bellingham, Aberdeen Hoquiam, Longview Kelso, Wenatchee, Yakima, Sunnyside, Richland Kennewick Pasco, and Walla Walla.~~))

Sec. 4. RCW 18.89.040 and 1987 c 415 s 5 are each amended to read as follows:

A respiratory care practitioner ((~~certified~~)) licensed under this chapter is employed in the treatment, management, diagnostic testing, rehabilitation, and care of patients with deficiencies and abnormalities which affect the cardiopulmonary system and associated aspects of other systems, and is under the direct order and under the qualified medical direction of a physician. The practice of respiratory care includes, but is not limited to:

(1) The use and administration of prescribed medical gases((~~, exclusive of general anesthesia~~));

(2) The use of air and oxygen administering apparatus;

(3) The use of humidification and aerosols;

(4) The administration, to the extent of training, of prescribed pharmacologic agents ((~~related to respiratory care~~));

(5) The use of mechanical ((~~or~~)) ventilatory, hyperbaric, and physiological ((~~ventilatory~~)) support;

(6) Postural drainage, chest percussion, and vibration;

(7) Bronchopulmonary hygiene;

(8) Cardiopulmonary resuscitation as it pertains to ((~~establishing airways and external cardiac compression~~)) advanced cardiac life support or pediatric advanced life support guidelines;

(9) The maintenance of natural and artificial airways, and insertion, ((~~without cutting tissues, of artificial airways,~~)) as ((~~ordered~~)) prescribed by ((~~the attending~~)) a physician;

(10) Diagnostic and monitoring techniques such as the collection and measurement of cardiorespiratory specimens, volumes, pressures, and flows; ((~~and~~))

(11) ((~~The drawing and analyzing of~~)) The insertion of devices to draw, analyze, infuse, or monitor pressure in arterial, capillary, ((~~and mixed~~)) or venous blood ((~~specimens~~)) as ((~~ordered~~)) prescribed by ((~~the attending~~)) a physician or an advanced registered nurse practitioner as authorized by the board of nursing under chapter 18.88 RCW;

(12) Diagnostic monitoring of and therapeutic interventions for desaturation, ventilatory patterns, and related sleep abnormalities; and

(13) The performance of such additional acts requiring education and training and which are jointly recognized by the medical and

respiratory professions as proper to be performed by respiratory care practitioners licensed under this chapter and which shall be authorized by the advisory committee for respiratory care through its rules and regulations.

Nothing in this chapter prohibits or restricts:

(a) The practice of a profession by individuals who are licensed under other laws of this state who are performing services within their authorized scope of practice, that may overlap the services provided by respiratory care practitioners;

(b) The practice of respiratory care by an individual employed by the government of the United States while the individual is engaged in the performance of duties prescribed for him or her by the laws and rules of the United States;

(c) The practice of respiratory care by a person pursuing a supervised course of study leading to a degree or certificate in respiratory care as a part of an accredited and approved educational program, if the person is designated by a title that clearly indicates his or her status as a student or trainee and limited to the extent of demonstrated proficiency of completed curriculum, and under direct supervision; or

(d) The use of the title "respiratory care practitioner" by registered nurses authorized under chapter 18.88 RCW.

Nothing in this chapter shall be construed to require that individual or group policies or contracts of an insurance carrier, health care service contractor, or health maintenance organization provide benefits or coverage for services and supplies provided by a person licensed under this chapter.

Sec. 5. RCW 18.89.050 and 1991 c 3 s 228 are each amended to read as follows:

(1) In addition to any other authority provided by law, the secretary, in consultation with the advisory committee, may:

(a) Adopt rules, in accordance with chapter 34.05 RCW, necessary to implement this chapter;

(b) Set all ((~~certification~~)) license, examination, and renewal fees in accordance with RCW 43.70.250;

(c) Establish forms and procedures necessary to administer this chapter;

(d) Issue a ((~~certificate~~)) license to any applicant who has met the education, training, and examination requirements for ((~~certification~~)) licensure;

(e) Hire clerical, administrative, and investigative staff as needed to implement this chapter and hire individuals ((~~certified~~)) licensed under this chapter to serve as examiners for any practical examinations;

(f) Approve those schools from which graduation will be accepted as proof of an applicant's eligibility to take the ((~~certification~~)) licensure examination;

(g) Prepare, grade, and administer, or determine the nature of, and supervise the grading and administration of, examinations for applicants for ((~~certification~~)) licensure;

(h) Determine whether alternative methods of training are equivalent to formal education and establish forms, procedures, and criteria for evaluation of an applicant's alternative training to determine the applicant's eligibility to take the examination;

(i) Determine which states have legal credentialing requirements equivalent to those of this state and issue ((~~certificates~~)) licenses to individuals legally credentialed in those states without examination; and

(j) Define and approve any experience requirement for ((~~certification~~)) licensure.

(2) The provisions of chapter 18.130 RCW shall govern the issuance and denial of ((~~certificates, uncertified~~)) licenses, unlicensed practice, and the disciplining of persons ((~~certified~~)) licensed under this chapter. The secretary shall be the disciplining authority under this chapter.

Sec. 6. RCW 18.89.060 and 1991 c 3 s 229 are each amended to read as follows:

The secretary shall keep an official record of all proceedings, a part of which record shall consist of a register of all applicants for ((~~certification~~)) licensure under this chapter, with the result of each application.

Sec. 7. RCW 18.89.070 and 1991 c 3 s 230 are each amended to read as follows:

(1) There is created a state respiratory care advisory committee consisting of five members appointed by the secretary. Three members of the advisory committee shall be respiratory care practitioners who are ((~~certified~~)) licensed under this chapter. The initial members, however, may be appointed to the advisory committee if they meet all the requirements for ((~~certification~~)) licensure under this chapter and have been engaged in the practice of respiratory care for at least five years. One member of the advisory committee shall be an individual representing the public who is unaffiliated with the profession. One member of the advisory committee shall be a physician, who is a pulmonary specialist. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his or her predecessor was appointed shall be appointed for the remainder of such term and the terms of office of the members first taking office shall expire, as designated at the time of appointment, one at the end of the first year, one at the end of the second year, one at the end of the third year, and two at the end of the fourth year after the date of appointment. Thereafter all appointments shall be for four years. Any advisory committee member may be removed for just cause. The secretary may appoint a new member to fill any vacancy on the advisory committee for the remainder of the unexpired term. No advisory committee member may serve more than two consecutive terms, whether full or partial.

(2) Advisory committee members shall be entitled to be compensated in accordance with RCW 43.03.240, and to be reimbursed for travel expenses under RCW 43.03.050 and 43.03.060.

(3) The advisory committee shall have the authority to elect annually a chairperson and vice-chairperson to direct the meetings of the advisory committee. The advisory committee shall meet at least once each year, and may hold additional meetings as called by the secretary or the chairperson. Three members of the advisory committee constitute a quorum.

Sec. 8. RCW 18.89.080 and 1991 c 3 s 231 are each amended to read as follows:

The secretary, members of the advisory committee, or individuals acting on their behalf are immune from suit in any civil action based on any ((~~certification~~)) licensure or disciplinary proceedings, or other official acts performed in the course of their duties.

Sec. 9. RCW 18.89.090 and 1991 c 3 s 232 are each amended to read as follows:

The secretary shall issue a ((~~certificate~~)) license to any applicant who demonstrates to the secretary's satisfaction that the following requirements have been met:

(1) Graduation from a school approved by the secretary or successful completion of alternate training which meets the criteria established by the secretary;

(2) Successful completion of an examination administered or approved by the secretary;

(3) Successful completion of any experience requirement established by the secretary;

(4) Good moral character.

In addition, applicants shall be subject to the grounds for denial or issuance of a conditional ((~~certificate~~)) license under chapter 18.130 RCW.

A person who meets the qualifications to be admitted to the examination for ((~~certification~~)) licensure as a respiratory care practitioner may practice as a respiratory care practitioner under the supervision of a respiratory care practitioner ((~~certified~~)) licensed under this chapter between the date of filing an application for ((~~certification~~)) licensure and the announcement of the results of the next succeeding examination for ((~~certification~~)) licensure if that person applies for and takes the first examination for which he or she is eligible.

The secretary shall establish by rule what constitutes adequate proof of meeting the criteria.

Sec. 10. RCW 18.89.110 and 1991 c 3 s 234 are each amended to read as follows:

(1) The date and location of the examination shall be established by the secretary. Applicants who have been found by the secretary to meet the other requirements for ((~~certification~~)) licensure shall be scheduled for the next examination following the filing of the application. However, the applicant shall not be scheduled for any examination taking place sooner than sixty days after the application is filed.

(2) The secretary shall examine each applicant, by means determined most effective, on subjects appropriate to the scope of practice. Such

examinations shall be limited to the purpose of determining whether the applicant possesses the minimum skill and knowledge necessary to practice competently, and shall meet generally accepted standards of fairness and validity for ((~~certification~~)) licensure examinations.

(3) All examinations shall be conducted by the secretary, and all grading of the examinations shall be under fair and wholly impartial methods.

(4) Any applicant who fails to make the required grade in the first examination is entitled to take up to three subsequent examinations, upon the prepayment of a fee determined by the secretary as provided in RCW 43.70.250 for each subsequent examination. Upon failure of four examinations, the secretary may invalidate the original application and require such remedial education as is deemed necessary.

(5) The secretary may approve an examination prepared and administered by a private testing agency or association of credentialing boards for use by an applicant in meeting the ((~~certification~~)) licensure requirement.

Sec. 11. RCW 18.89.120 and 1991 c 3 s 235 are each amended to read as follows:

Applications for ((~~certification~~)) licensure shall be submitted on forms provided by the secretary. The secretary may require any information and documentation which reasonably relates to the need to determine whether the applicant meets the criteria for ((~~certification~~)) licensure provided in this chapter and chapter 18.130 RCW. All applications shall be accompanied by a fee determined by the secretary under RCW 43.70.250.

Sec. 12. RCW 18.89.130 and 1991 c 3 s 236 are each amended to read as follows:

(1) The secretary shall waive the examination and grant a ((~~certificate~~)) license to a person engaged in the profession of respiratory care in this state on July 26, 1987, if the secretary determines the person meets commonly accepted standards of education and experience for the profession and has previously achieved an acceptable grade on an approved examination administered by a private testing agency or respiratory care association as established by rule of the secretary.

(2) If an individual is engaged in the practice of respiratory care on July 26, 1987, but has not achieved an acceptable grade on an approved examination administered by a private testing agency, the individual may apply to the secretary for examination. This section shall only apply to those individuals who file an application within one year of July 26, 1987.

Sec. 13. RCW 18.89.140 and 1991 c 3 s 237 are each amended to read as follows:

The secretary shall establish by rule the requirements for continuing education and fees for renewal of ((~~certificates~~)) licenses. Failure to renew shall invalidate the ((~~certificate~~)) license and all privileges granted by the ((~~certificate~~)) license. In the event a ((~~certificate~~)) license has lapsed for a period longer than three years, the ((~~certified~~)) licensed respiratory care practitioner shall demonstrate competence to the satisfaction of the secretary by continuing education or under the other standards determined by the secretary.

Sec. 14. RCW 18.120.020 and 1989 c 300 s 14 are each amended to read as follows:

The definitions contained in this section shall apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant group" includes any health professional group or organization, any individual, or any other interested party which proposes that any health professional group not presently regulated be regulated or which proposes to substantially increase the scope of practice of the profession.

(2) "Certificate" and "certification" mean a voluntary process by which a statutory regulatory entity grants recognition to an individual who (a) has met certain prerequisite qualifications specified by that regulatory entity, and (b) may assume or use "certified" in the title or designation to perform prescribed health professional tasks.

(3) "Grandfather clause" means a provision in a regulatory statute applicable to practitioners actively engaged in the regulated health profession prior to the effective date of the regulatory statute which exempts the practitioners from meeting the prerequisite qualifications set forth in the regulatory statute to perform prescribed occupational tasks.

(4) "Health professions" means and includes the following health and health-related licensed or regulated professions and occupations: ((~~Podiatry~~)) Podiatric medicine and surgery under chapter 18.22 RCW; chiropractic under chapters 18.25 and 18.26 RCW; dental hygiene under chapter 18.29 RCW; dentistry under chapter 18.32 RCW; dispensing opticians under chapter 18.34 RCW; hearing aids under chapter 18.35 RCW; naturopaths under chapter 18.36A RCW; embalming and funeral directing under chapter 18.39 RCW; midwifery under chapter 18.50 RCW; nursing home administration under chapter 18.52 RCW; optometry under chapters 18.53 and 18.54 RCW; ocularists under chapter 18.55 RCW; osteopathy and osteopathic medicine and surgery under chapters 18.57 and 18.57A RCW; pharmacy under chapters 18.64 and 18.64A RCW; medicine under chapters 18.71, 18.71A, and 18.72 RCW; emergency medicine under chapter 18.73 RCW; physical therapy under chapter 18.74 RCW; practical nurses under chapter 18.78 RCW; psychologists under chapter 18.83 RCW; registered nurses under chapter 18.88 RCW; occupational therapists licensed pursuant to chapter 18.59 RCW; respiratory care practitioners ((~~certified~~)) licensed under chapter 18.89 RCW; veterinarians and animal technicians under chapter 18.92 RCW; health care assistants under chapter 18.135 RCW; massage practitioners under chapter 18.108 RCW; acupuncturists certified under chapter 18.06 RCW; persons registered or certified under chapter 18.19 RCW; dietitians and nutritionists certified by chapter 18.138 RCW; radiologic technicians under chapter 18.84 RCW; and nursing assistants registered or certified under chapter 18.88A RCW.

(5) "Inspection" means the periodic examination of practitioners by a state agency in order to ascertain whether the practitioners' occupation is being carried out in a fashion consistent with the public health, safety, and welfare.

(6) "Legislative committees of reference" means the standing legislative committees designated by the respective rules committees of the senate and house of representatives to consider proposed legislation to regulate health professions not previously regulated.

(7) "License," "licensing," and "licensure" mean permission to engage in a health profession which would otherwise be unlawful in the state in the absence of the permission. A license is granted to those individuals who meet prerequisite qualifications to perform prescribed health professional tasks and for the use of a particular title.

(8) "Professional license" means an individual, nontransferable authorization to carry on a health activity based on qualifications which include: (a) Graduation from an accredited or approved program, and (b) acceptable performance on a qualifying examination or series of examinations.

(9) "Practitioner" means an individual who (a) has achieved knowledge and skill by practice, and (b) is actively engaged in a specified health profession.

(10) "Public member" means an individual who is not, and never was, a member of the health profession being regulated or the spouse of a member, or an individual who does not have and never has had a material financial interest in either the rendering of the health professional service being regulated or an activity directly related to the profession being regulated.

(11) "Registration" means the formal notification which, prior to rendering services, a practitioner shall submit to a state agency setting forth the name and address of the practitioner; the location, nature and operation of the health activity to be practiced; and, if required by the regulatory entity, a description of the service to be provided.

(12) "Regulatory entity" means any board, commission, agency, division, or other unit or subunit of state government which regulates one or more professions, occupations, industries, businesses, or other endeavors in this state.

(13) "State agency" includes every state office, department, board, commission, regulatory entity, and agency of the state, and, where provided by law, programs and activities involving less than the full responsibility of a state agency.

Sec. 15. RCW 18.130.040 and 1992 c 128 s 6 are each amended to read as follows:

(1) This chapter applies only to the secretary and the boards having jurisdiction in relation to the professions licensed under the chapters specified in this section. This chapter does not apply to any business or profession not licensed under the chapters specified in this section.

(2)(a) The secretary has authority under this chapter in relation to the following professions:

(i) Dispensing opticians licensed under chapter 18.34 RCW;

(ii) Naturopaths licensed under chapter 18.36A RCW;

(iii) Midwives licensed under chapter 18.50 RCW;

(iv) Ocularists licensed under chapter 18.55 RCW;

(v) Massage operators and businesses licensed under chapter 18.108 RCW;

(vi) Dental hygienists licensed under chapter 18.29 RCW;

(vii) Acupuncturists certified under chapter 18.06 RCW;

(viii) Radiologic technologists certified under chapter 18.84 RCW;

(ix) Respiratory care practitioners ((~~certified~~)) licensed under chapter 18.89 RCW;

(x) Persons registered or certified under chapter 18.19 RCW;

(xi) Persons registered as nursing pool operators;

(xii) Nursing assistants registered or certified under chapter ((~~18.52B~~)) 18.88A RCW;

(xiii) Dietitians and nutritionists certified under chapter 18.138 RCW;

(xiv) Sex offender treatment providers certified under chapter 18.155 RCW; and

(xv) Persons licensed and certified under chapter 18.73 RCW or RCW 18.71.205.

(b) The boards having authority under this chapter are as follows:

(i) The podiatric medical board as established in chapter 18.22 RCW;

(ii) The chiropractic disciplinary board as established in chapter 18.26 RCW governing licenses issued under chapter 18.25 RCW;

(iii) The dental disciplinary board as established in chapter 18.32 RCW;

(iv) The council on hearing aids as established in chapter 18.35 RCW;

(v) The board of funeral directors and embalmers as established in chapter 18.39 RCW;

(vi) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;

(vii) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

(viii) The board of osteopathic medicine and surgery as established in chapter 18.57 RCW governing licenses issued under chapters 18.57 and 18.57A RCW;

(ix) The medical disciplinary board as established in chapter 18.72 RCW governing licenses and registrations issued under chapters 18.71 and 18.71A RCW;

(x) The board of physical therapy as established in chapter 18.74 RCW;

(xi) The board of occupational therapy practice as established in chapter 18.59 RCW;

(xii) The board of practical nursing as established in chapter 18.78 RCW;

(xiii) The examining board of psychology and its disciplinary committee as established in chapter 18.83 RCW;

(xiv) The board of nursing as established in chapter 18.88 RCW; and

(xv) The veterinary board of governors as established in chapter 18.92 RCW.

(3) In addition to the authority to discipline license holders, the disciplining authority has the authority to grant or deny licenses based on the conditions and criteria established in this chapter and the chapters specified in subsection (2) of this section. However, the board of chiropractic examiners has authority over issuance and denial of licenses provided for in chapter 18.25 RCW, the board of dental examiners has authority over issuance and denial of licenses provided for in RCW 18.32.040, and the board of medical examiners has authority over issuance and denial of licenses and registrations provided for in chapters 18.71 and 18.71A RCW. This chapter also governs any investigation, hearing, or proceeding relating to denial of licensure or issuance of a license conditioned on the applicant's compliance with an order entered pursuant to RCW 18.130.160 by the disciplining authority.

NEW SECTION. **Sec. 16.** RCW 18.89.900 and 1987 c 415 s 20 are each repealed.

NEW SECTION. **Sec. 17.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1993.

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